U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of GLEN M. HAMMACK and DEPARTMENT OF THE AIR FORCE, KENTUCKY AIR NATIONAL GUARD, St. Augustine, FL

Docket No. 03-877; Submitted on the Record;
Issued September 8, 2003

DECISION and ORDER

Before ALEC J. KOROMILAS, MICHAEL E. GROOM,
A. PETER KANJORSKI

The issue is whether the Office of Workers' Compensation Programs properly terminated appellant's compensation effective April 17, 2002.

On December 2, 1996 appellant, then a 34-year-old mechanic, filed notice of traumatic injury and claim for compensation (Form CA-1) alleging that on October 4, 1996 while pushing a tow sweeper he experienced pain in his lower back, abdomen and left groin. In a January 24, 1997 report, Dr. John D. Crase, a Board-certified family practitioner, found a loss of L4-5 dermatomal sensation on the left side and bilateral loss of L4 reflexes and weakness on left heel walk. Dr. Crase diagnosed an acute lumbar strain affecting L3-4, pain in lower back and decreased strength in hip flexors and bilateral. Appellant was placed on light duty, no lifting greater than 10 pounds and referred for chiropractic care. In a January 16, 1997[1] note, Dr. Chris Rasmussen, a chiropractor, wrote that x-rays showed 15 degrees dextrorotatory scoliosis L2 though S1, open wedge abnormalities of L3-4 discs, failure of normal coupling at L3-4, L4-5, L5/S1 pelvic unleveling three fourth inch high on left. The claim was accepted for lumbar sprain and dislocation of a vertebrae. Appellant returned to light duty while receiving regular chiropractic treatments.

In a May 19, 1997 report, Dr. Rasmussen wrote that appellant's treatment was going well until a long weekend at work when he walked for hours on concrete and exacerbated his back condition. In a November 8, 1997 progress report, Dr. Crase indicated that appellant still experienced intermittent flare ups with overexertion consistent with nerve root irritations. He indicated that appellant's back pain could be caused by a bulging disc that would be exacerbated by overexertion.

[1] Dr. Rasmussen's report is dated January 16, 1996. This appears to be a typo as he listed October 4, 1996 as the date of injury.

On November 23, 1998 appellant stopped work due to pain. In a November 17, 1998 report, Dr. Rasmussen wrote that appellant's recovery had been slowed by the physical demands of his light-duty work and he was concerned appellant could become a chronic pain patient. He recommended appellant not work for four weeks to provide time for more aggressive therapy and to allow the surrounding soft tissues to heal and strengthen. In a December 2, 1998 letter, Dr. Crase wrote that appellant has shown steady but slow improvement through chiropractic treatments. He recommended appellant be off work for four weeks in order to pursue more aggressive therapy including work hardening. In a December 9, 1998 letter, the Office approved appellant taking four weeks off. Appellant has not returned to work at the employing establishment.

In an April 8, 1999 letter, the Office referred appellant to vocational rehabilitation. In an April 22, 1999 report, Dr. Rasmussen wrote that appellant was in his fifth week of a work hardening program when he experienced complications; appellant had a major increase in the vagovagal episodes where he has had significant abdominal and bowel distress with an increase in low back pain and pain radiating into the legs. According to Dr. Rasmussen, appellant indicated that he had episodes where his knees seemed to buckle and he experienced foot drop. Dr. Rasmussen attributed these symptoms to the aggressive work hardening program. On examination he found appellant to have biomechanical restrictions of the lower lumbar region and point tenderness over L4-5 as well as L3.

On August 26, 1999 appellant started classes in accounting at a community college. In an April 6, 2000 letter, the Office requested an updated medical report from Dr. Crase. In a May 1, 2000 response, Dr. Crase indicated that he had not treated appellant for his back condition for more than a year. In a June 1, 2000 report, Dr. Rasmussen wrote that appellant continued to have problems associated with vagovagal syncope, which caused severe cramping and abdominal distress usually associated with irritation in the lower back. He indicated that appellant had a protrusion of a disc in the lumbar spine, which was associated with autonomic nervous system irritation and pain in the left hip, buttocks and leg and occasional foot drag. Dr. Rasmussen wrote that since appellant started college he has experienced fatigue and weakness in the right arm and numbness in the right hand and arm, which caused difficulty keyboarding and was indicative of a neurological problem associated with the lower back or a vascular problem.

In a May 25, 2001 letter, the Office notified appellant that a chiropractor could not be his treating physician and the Office would no longer pay for treatment by Dr. Rasmussen. The Office recommended appellant submit a medical report from an osteopath or a medical physician. In a May 29, 2001 letter, the Office referred appellant for a second opinion.

In a June 29, 2001 report, Dr. Andrew DeGruccio, a Board-certified orthopedist, wrote that appellant presented with pain at a 5-6/10 level in the lumbar and neck areas and with complaints of foot drag. On examination Dr. DeGruccio found that appellant had no significant antalgia, excellent coordination and balance. Appellant's heel-toe walking also demonstrated excellent strength and coordination in the lower extremities with no suggestion of foot drag. Appellant was unable to get completely to his toes. Dr. DeGruccio found that appellant voluntarily guarded against reflex testing, but when distracted normal reflexes were discovered. He found that appellant had negative straight leg raising test, negative Stenchfield, negative

Faber sign, although appellant suggested he has reproduction of low back pain with leg raising. Dr. DeGruccio did not feel any further testing was necessary. He found that appellant's symptoms were subjective and showed suggestions of inappropriate pain behavior and indicated the symptoms were somaticized. He opined that appellant's back strain had resolved and his symptoms were a residual from his chiropractic treatment. Dr. DeGruccio indicated that appellant had no physical restrictions, but psychologically appellant might not be ready to return to work. He diagnosed chronic lumbar strain pattern back pain with symptoms and signs of inappropriate behavior. He further opined that appellant could return to his date-of-injury position with restrictions of no twisting, no lifting more than 35 pounds repetitively and no more than 60 to 70 pounds. Dr. DeGruccio recommended against further chiropractic treatments, but noted that appellant may need psychological and biofeedback counseling as most of his problems were not physical.

In an August 13, 2001 letter, responding to an Office request for more information, Dr. DeGruccio wrote that appellant no longer had a low back condition connected to the accepted injury. He indicated that he found no objective evidence to support continued and persistent back pain. He noted there was no objective evidence that appellant could not return to his date-of-injury job and that he only restricted appellant's twisting because of the subjective complaints of pain.

In a September 8, 2001 report, Dr. Crase wrote that appellant has been treated by Dr. Rasmussen for the work-related right lateral disc herniation at the L4-5 level. The specific deficits were chronic back and abdominal pain. The abdominal pain was referred from his back during acute exacerbations and his chronic back pain decreased his ability to work.

On November 7, 2001 appellant elected disability retirement benefits.

In a November 13, 2001 letter, the Office referred appellant for a psychiatric evaluation. In a December 27, 2001 report, Dr. David Kissel, a Board-certified psychiatrist, wrote that appellant indicated that he was under stress for several reasons, including the fact medical compensation was terminated for his chiropractic care, financial difficulties though he was working as special education tutor, and ongoing chronic back pain and unresolved grief over the death of his stepfather. Dr. Kissel indicated that appellant denied any psychiatric symptoms preventing him from working. He found no evidence that appellant had a psychological or emotional condition due to his accepted work injury and recommended no further psychological treatment.

In a March 15, 2002 letter, the Office proposed terminating appellant's benefits finding the weight of the medical evidence rested with Drs. DeGruccio and Kissel. Appellant was given 30 days to submit additional evidence. In an April 1, 2002 letter, appellant requested more time to obtain the necessary medical reports. No additional evidence was submitted. In an April 17, 2002 decision, the Office terminated appellant's compensation finding that the medical evidence established that his work-related conditions had resolved.

In an August 23, 2002 letter, appellant requested reconsideration and submitted additional medical evidence. In an April 8, 2002 report, Dr. John Conner, a Board-certified orthopedist, wrote that appellant presented with moderate to sometimes severe pain that radiated

bilaterally to his ankles, left lateral leg tingling with occasional weakness and dorsiflexion on the left. On physical examination Dr. Cooner found appellant in no apparent distress with no sensory deficits and bilateral positive straight leg raising. He diagnosed appellant with ongoing degenerative disc disease. He recommended continue chiropractic treatment In an August 13, 2002 progress note Dr. Rasmussen, wrote that appellant had a failure of biomechanical motion at L3-4, open disc wedge at L3-4 and L2-3, a biomechanical loss of function at the lumbosacral area indicating a potential disc bulge and failure at L2-3 and L3-4.

In an October 24, 2002 decision, the Office denied modification of its April 17, 2002 decision, finding the medical evidence insufficient in that it lacked rationale showing how appellant's back condition was related to the accepted conditions.

The Board finds that the Office properly terminated appellant's compensation effective April 17, 2002.

Once the Office has accepted a claim, it has the burden of justifying termination or modification of compensation benefits.[2] The Office may not terminate compensation without establishing that the disability ceased or that it was no longer related to the employment.[3] After termination or modification of compensation benefits, clearly warranted on the basis of the evidence, the burden for reinstating compensation benefits shifts to appellant. In order to prevail, appellant must establish by the weight of the reliable, probative and substantial evidence that he or she had an employment-related disability, which continued after termination of compensation benefits.[4]

In the present case, the Office relied on the reports of Drs. DeGruccio and Kissel, in terminating appellant's compensation. In his June 29, 2001 report, Dr. DeGruccio, a Board-certified orthopedist, who served as an Office referral physician, wrote that he completed a thorough examination of appellant and found appellant's symptoms were subjective and that he showed suggestions of inappropriate pain behavior and believed the symptoms were somaticized. Dr. DeGruccio diagnosed chronic lumbar strain pattern back pain with symptoms and signs of inappropriate behavior. He further opined that appellant could return to his date-of-injury position with restrictions. In his August 13, 2001 report, Dr. DeGruccio wrote that appellant no longer had from a low back strain connected to the accepted injury. He found no objective evidence to support continued and persistent back pain and there was no objective evidence that appellant could not return to his date-of-injury job.

Dr. Kissel, a Board-certified psychiatrist, who served as an Office referral physician, wrote that appellant neither complained of, or demonstrated any psychological or emotional condition related to the accepted work injury that prevented him for working.

[2] *Charles E. Minniss,* 40 ECAB 708, 716 (1989); *Vivien L. Minor,* 37 ECAB 541, 546 (1986).

[3] *Id.*

[4] *Wentworth M. Murray*, 7 ECAB 570, 572 (1955).

These medical reports represent the weight of the medical evidence for several reasons. In his May 31, 2001 report Dr. Rasmussen,[5] did not provide a rationalized explanation how appellant's condition was related to the accepted injury; nor did he indicate that appellant was disabled, though he continued to receive treatments for pain on an as need basis. Dr. Crase's reports have diminished probative value because he had not seen appellant since 1999. Furthermore, Dr. DeGruccio is a Board-certified orthopedist, while Dr. Crase's specialty is in family medicine. In a May 25, 2001 letter, the Office notified appellant of the deficiencies in his medical evidence and suggested he obtain a report from a medical physician or osteopath with a relevant specialty, but appellant did not take that recommendation. For these reasons the Board finds that the Office properly terminated appellant's compensation.

After the Office's April 17, 2002 decision, terminating appellant's compensation appellant submitted additional medical evidence. The Board has reviewed the additional evidence submitted by appellant and finds that it is not of sufficient probative value to establish that he had continuing residuals of his employment injury after April 17, 2002. Dr. Rasmussen's reports lack a rationalized explanation how appellant's condition was related to the accepted condition. Dr. Conner's April 8, 2002 report supports that appellant had an ongoing back condition, but it does not relate his back condition to the accepted injury. Furthermore, Dr. Conner diagnosed appellant with probable disc bulge and degenerative disc disease. His report is both speculative and contains a diagnosis, degenerative disc disease, that was not accepted by the Office. For these reasons the Board finds that appellant has not met his burden of proof to establish ongoing disability after April 17, 2002.

[5] Under section 8101(2) of the Federal Employees' Compensation Act, chiropractors are only considered physicians and their reports considered medical evidence, to the extent that they treat spinal subluxations as demonstrated by x-ray to exist. However, the Office regulations at 20 C.F.R. 10.5(bb) define subluxation as an incomplete dislocation, off centering, misalignment, fixation or abnormal spacing of the vertebrae anatomically. As the Office has accepted appellant's claim for a dislocation of a vertebrae and Dr. Rasmussen discussed appellant's condition in term of wedge abnormalities and dislocation, he is considered a physician under the Act. *See Larry R. Kozak*, Docket No. 00-1080 (issued April 20, 2001).

The decisions of the Office of Workers' Compensation Programs dated October 24 and April 17, 2002 are hereby affirmed.

Dated, Washington, DC
September 8, 2003

Alec J. Koromilas
Chairman

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member